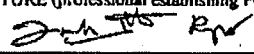



Exhibit 21

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
HEALTH CARE FINANCING ADMINISTRATIONFORM APPROVED
OMB NO. 0938-0227

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION (COMPLETE FOR INITIAL CLAIMS ONLY)

1. PATIENT'S LAST NAME		FIRST NAME		M.I.	2. PROVIDER NO.	3. HICN
4. PROVIDER NAME POINTE PHYSICAL THERAPY		5. MEDICAL RECORD NO. (Optional)			6. ONSET DATE 09.05.2010	7. SOC DATE 10.05.2010
8. TYPE: <input checked="" type="checkbox"/> P T <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> R T <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW		9. PRIMARY DIAGNOSIS (Permanent Medical D.X.) LUMBAR STRAIN WITH RADICULO PATHY			10. TREATMENT DIAGNOSIS LUMBAR STRAIN WITH RADICULOPATHY	11. VISITS FROM SOC.
12. PLAN OF TREATMENT FUNCTIONAL GOALS GOALS (Short Term IN 2 WEEKS) 1. DEC PAIN @ LOWER BACK TO 5/10 ON 0/10 SCALE. 2. DEC TENDERNESS @ LOWER BACK TO 3/5 ON 0/5 SCALE. INC ROM @ LS BY 10 DEGREE IN ALL PLANES. 4. ESTABLISH HEP OUTCOME (Long Term IN 4 WEEKS) DEC PAIN @ LOWER BACK TO 0-1/10 ON 0/10 SCALE. 2. DEC TENDERNESS @ LOWER BACK TO 0-1/5 ON 0/5 SCALE. 3. INC ROM @ LS TO WFL. 4. INC MMSTR TO WFL. 5. INC FUNCTIONAL MOBILITY IN ADLS PAIN FREE					PLAN 1. IFC WITH MHP/CP TO THE MID & LOWER BACK FOR 15 - 20 MTS 2. THX US INCLUDES 1MHZ @ 1.2 W/CM2 TO THE LS X 8 MTS 3. FUNCTIONAL MASSAGE FOR 1 X 10 MTS 4. INSTRUCT AND EDUCATE HEP 5. THX EXCS INCLUDES AROM AND STRETCHING EXCS TO LOWER BACK BOTH LE FOR 15-30 MTS	
13. SIGNATURE (professional establishing POC including prof. designation) 					14. FREQ/DURATION (e.g., 3/Wk, x 4 Wk.) 2-3/WK/4/WK	
I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE <input type="checkbox"/> N/A 15. PHYSICIAN'S SIGNATURE  16. DATE 9-20-10					17. CERTIFICATION FROM 09.22.2010 THROUGH 10.21.2010 <input type="checkbox"/> N/A 18. ON FILE (Print type physician's name) DR MARTIN QUIROGA	
20. INITIAL ASSESSMENT (History, medical complications, level of function at start of care. Reason for referral)					19. PRIOR HOSPITALIZATION FROM TO <input type="checkbox"/> N/A	

a 50 yr old male came to the clinic with diagnosis of lumbar strain with radiculopathy. the patient reported that he met with an accident on 09/01/2010 since then the pain has started. pt c/o pain and stiffness in low back & is radiating to both lower extremities causing difficulty in functional mobility and adl. p/hx, patient was independent in adl and functional mobility prior to the episode. social history: patient is single, worked as a chef and is unemployed right now. past medical history: patient underwent surgery for appendectomy when he was 18 yrs, patient admitted to hospital two times within last two yrs with pulmonary embolism, & is on medication for high bp. functional status: pain level at ls is about 7/10 on 0/10 scale and tenderness is about 4/5 on 0/5 scale. spasm at ls 4+/5 on 0-5 scale. arom @ls is restricted due to pain. muscle power is about 3/5 on 0-5 scale endurance is poor. balance static/dynamic: good. pt has max difficulty to go up & down stairs, mod difficulty to get in & out of the car and bath tub patient has max difficulty to get up from the low height chair. also has mod/max difficulty with bed mobility. patient max pain with right side bending, and rotations. patient c/o pain with walking >10 mts pt is unable to sleep on stomach for >5-10 mts, max difficulty to sit for >10-15 mts and max difficulty to stand for >10-15 mt. patient has max difficulty to reach for object from floor due to pain special test: positive crossed slr test. pre cautions: patient is advised to avoid sudden jerky, twisting and turning and repeated forward bending at lower back. pt is alert and oriented and has a good rehab potential.

DEPARTMENT OF HEALTH AND HUMAN RESOURCES HEALTH CARE FINANCING ADMINISTRATION		Location <input checked="" type="checkbox"/> Clinic <input type="checkbox"/> Patient's home		FORM APPROVED OMB NO. 0938-022	
UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION (Complete for interim to Discharge Claims. Photocopy of HCFA-700 or 701 is required)					
1. PATIENT'S LAST NAME		FIRST NAME		M.I.	
2. PROVIDER NO.		3. HICN			
4. PROVIDER NAME POINT PHYSICAL THERAPY		5. MEDICAL RECORD NO. (Optional)		6. ONSET DATE 09.05.2010	
7. SOC DATE 10.05.2010		8. TYPE: <input checked="" type="checkbox"/> P T <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> R T <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW		9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.) LUMBAR STRAIN WITH RADICULO PATHY	
10. TREATMENT DIAGNOSIS LUMBAR STRAIN WITH RADICULOPATHY/RIGH T FOOT DERANGEMENT		11. VISITS FROM SOC.			
12. FREQ/DURATION (e.g., 3 wk x 4 wk) 2-3 WK X 4WKS					
13. CURRENT PLAN UPDATE, FUNCTIONAL GOALS (Specify changes to goals & plan of care) GOALS OUTCOME (Long Term) Goals <input type="checkbox"/> met <input checked="" type="checkbox"/> not met DEC PAIN @ LOWER BACK TO 0-1/10 ON 0/10 SCALE 2. DEC TENDERNESS @ LOWER BACK TO 0-1/5 ON 0/5 SCALE 3. INC ROM @ LS TO WFL 4. INC MMSTR TO WFL 5. INC FUNCTIONAL MOBILITY IN ADLS PAIN FREE			PLAN 1. IFC WITH MHP/CP TO THE MID & LOWER BACK FOR 15 -20MTS 2. THX US INCLUDES 1MHZ@1.2 W/CM2 TO THE LS FO 8MTS 3. FUNCTIONAL MASSAGE TO LS FOR 1 X 10 MTS 4. HEP 5THX EXCS INCLUDES AROM AND STRETCHING EXC cTO LOWER BACK BOTH LE FOR 30 MTS		
I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. 15. PHYSICIAN'S SIGNATURE			16. DATE 12/2/11		
14. RECERTIFICATION FROM 11.22.2010 THROUGH 12.21.2010 N/A <input type="checkbox"/>			17. ON FILE (Print/type physician's name) DR MARTIN QUIROGA Dr. Ruden		
18. REASON (S) FOR CONTINUING TREATMENT THIS BILLING PERIOD (Clarify goals and necessity for continued skilled care) patient received 9 pt tx sessions during the last billing period. pt has progressed with each treatment sessions since soc and his treatment goals. pt's functional status is as follows.: patient demonstrated dec pain level at ls & is about 5/10 on 0/10 scale and tenderness is about 3+/5 on ls & 4/5 @ right foot 0/5 scale. spasm at ls 4/5 on 0-5 scale. arom @ls is restricted moderately due to pain..muscle power is about 3+/5 on 0-5 scale endurance is fair- .balance static/dynamic : good .. pt has max/mod difficulty to go up & down stairs ,mod difficulty to get in & out of the car and bath tub patient has max/mod difficulty to get up from the low height chair .also has mod difficulty with bed mobility .patient has max/mod pain with right side bending ,and rotations .patient c/o pain with walking >10-15 mts pt has max difficulty to sleep on stomach for >10-20 mts, max difficulty to sit for >15-20 mts and max difficulty to stand for > 10- 15 mt. patient has max difficulty to reach for object from floor due to pain. patient is alert and oriented .and has good rehab potential .continue pt for another 2-3 weeks.					
19. SIGNATURE (or name of professional, including prof. Designation) Dustin For		20. DATE 11.22.2010		21. <input checked="" type="checkbox"/> CONTINUE SERVICES OR <input type="checkbox"/> DC SERVICES	
22. FUNCTIONAL LEVEL (at end of billing period - Relate your documentation to functional outcome and list problems still					
23. SERVICE DATES FROM THROUGH					

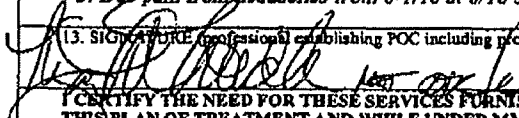

FROM: 5867/46005

10/05/2010 10:03

#025 P.002/002

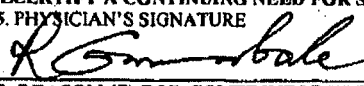
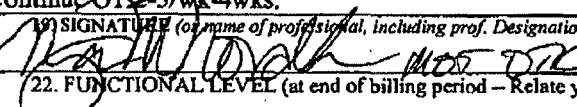
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
HEALTH CARE FINANCING ADMINISTRATIONFORM APPROVED
OMB NO. 0938-0227

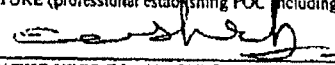

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION (COMPLETE FOR INITIAL CLAIMS ONLY)


1. PATIENT'S LAST NAME		1. FIRST NAME		M.I.		2. PROVIDER NO.		3. HICN	
4. PROVIDER NAME PONTE PHYSICAL THERAPY		5. MEDICAL RECORD NO. (Optional)		6. ONSET DATE 09.01.2010		7. SOC DATE 10.05.2010			
8. TYPE: <input type="checkbox"/> PT <input checked="" type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> RT <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW		9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.) CERVICAL STRAIN, POST CONCUSSIVE HEADACHES		10. TREATMENT DIAGNOSIS Neck Pain, Upper Back Pain, Inc Tend and Stiffness., Headaches, Dec FN mobility		11. VISITS FROM SOC.			
12. PLAN OF TREATMENT FUNCTIONAL GOALS GOALS (Short Term) 1. Dec pain at CS to 5/10 at 0-10 scale in 2 wks. 2. Dec tend at CS to 2/5 at 0-5 scale in 2 wks. 3. Inc mmstr at CS to 1/2 grade. 4. Establish HEP 5. Dec pain from headaches from 8/10 at 0-10 scale in 2 wks. OUTCOME (Long Term) 1. Dec pain at CS to 0-1/10 on 0-10 scale in 4wks 2. Dec tend at CS to 0-1/5 on 0-5 scale in 4wks. 3. Inc mmstr at CS to WFL. 4. Inc functional mobility in ADL's pain free. 5. Dec pain from headaches from 0-1/10 at 0/10 scale in 4 wks.				PLAN 1. Thx at CS aarom /arom/pre /stretching/strengthening activities. 2. Instruct & educate HEP. 3. MHP with IFC to CS. 4. Manual Therapy to CS. 5. instruct & educate on compensatory strategies for headaches					
13. SIGNATURE (professional) establishing POC including prof. designation) 				14. FREQ/DURATION (e.g., 3/Wk. x 4 Wk.) 3/Wk x 4 Wk					
15. CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE <input type="checkbox"/> N/A 15. PHYSICIAN'S SIGNATURE  16 DATE 10.1.10				17. CERTIFICATION FROM 10.05.2010 THROUGH 11.04.2010 <input type="checkbox"/> N/A 18. ON FILE (Print type physician's name) Dr. QUIROGA					
20. INITIAL ASSESSMENT (History, medical complications, level of function at start of care. Reason for referral)				19. PRIOR HOSPITALIZATION FROM TO <input type="checkbox"/> N/A					

This 50 yr male came to the clinic with the diagnosis cervical strain as well as post concussive headaches. Pt reported that he met with an accident on 09.01.2010 & pain started since then. Pt c/o severe pain and stiffness in his neck and back causing difficulty in fn mobility's & ADL's. Pt c/o of constant pain and severe headaches and dizziness. **PLOF:** Pt was Independent in ADL's & functional mobility prior to this episode. **SOCIAL HISTORY:** Single, PTA worked as a chef. **PAST MEDICAL HISTORY:** hx of pulmonary embolisms in the last 2 yrs, increased blood pressure, currently not on medication for either dx. **FUNCTIONAL STATUS** of pt is as follows Pain level at CS 8-9/10 on 0-10 scale. Tenderness at CS 4+/5 on 0-5 scale. Spasm at neck and shoulders that run down bil arms and lower back. Endurance poor, Pt is unable to cook and clean the house, c/o pain and dizziness mod/max difficulty during dressing and grooming, unable to sleep on sides >15-20min, sit to watch TV >15-20 min. ADL task Feeding independent, Grooming max-mod A, Washing UB max A- mod A, LB mod A- min A, Dressing UB mod A, LB mod A- min A, Toileting independent, c/o pain during Bed mobility & transfers, ADL transfer sit to stand 1. **SPECIAL TEST:** Cervical Compression test +ve, **PRECAUTIONS:** Patient is advised to avoid sudden jerky, twisting and turning neither movements at spine, nor lift heavy weight at this time. Pt's co-ordination is fair. Pt is alert and oriented and has good rehab potential.

Received Time Oct. 6. 2010 3:50PM No. 0518

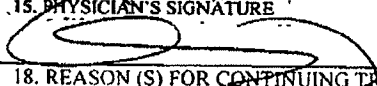
DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION		Location <input checked="" type="checkbox"/> Clinic <input type="checkbox"/> Patient's home		FORM APPROVE OMB NO. 0938-022	
UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION (Complete for interim to Discharge Claims. Photocopy of HCFA-700 or 701 is required)					
1. PATIENT'S LAST NAME		FIRST NAME		M.I.	
2. PROVIDER NO.		3. HICN			
4. PROVIDER NAME Pointe Physical Therapy		5. MEDICAL RECORD NO. (Optional)		6. ONSET DATE 09/01/2010	
7. SOC DATE 10/05/2010		8. TYPE: <input type="checkbox"/> P T <input checked="" type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> R T <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW		9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.) CERVICAL STRAIN, POST CONCUSSIVE HEADACHES	
10. TREATMENT DIAGNOSIS Neck Pain, Upper Back Pain, Shoulder Pain, Inc Tend and Stiffness, Headaches, Dec FN mobility		11. VISITS FROM SOC.			
12. FREQ/DURATION (e.g., 3 wk x 4 wk) 3 WK X 4WKS		13. CURRENT PLAN UPDATE, FUNCTIONAL GOALS (Specify changes to goals & plan of care) GOALS.			
OUTCOME (Long Term) Goals <input type="checkbox"/> met <input checked="" type="checkbox"/> not met		PLAN			
1. Dec pain at CS to 0-1/10 on 0-10 scale in 4wks		1. Thx aarom /arom/pre at CS /stretching/balance activities.			
2. Dec tend at CS to 0-1/5 on 0-5 scale in 4wks.		2. Instruct & educate HEP.			
3. Inc mmstr at CS to WFL.		3. Therapeutic US to CS 3.3MHz 1.3W/cm2 x 08 min.			
4. Inc functional mobility in ADL's pain free.		4. MHP with IFC to CS.			
5. Dec pain from headaches from 0-1/10 at 0/10 scale in 4 wks.		5. Manual Therapy to CS.			
6. instruct & educate on compensatory strategies for headache		6. instruct & educate on compensatory strategies for headache			
I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. <input type="checkbox"/> N/A <input type="checkbox"/> DC		14. RECERTIFICATION FROM THROUGH N/A <input type="checkbox"/>			
15. PHYSICIAN'S SIGNATURE 		16. DATE 11/05/2010			
17. ON FILE (Print /type physician's name) Dr. QUIROGA		18. REASON (S) FOR CONTINUING TREATMENT THIS BILLING PERIOD (Clarify goals and necessity for continued skilled care)			
<p>Patient received 10 OT tx sessions during the last billing period. Pt's functional status is as follows: Pt demo dec Pain level in CS from 8/10 to 7/10 on 0-10 scale. Pt demo dec Tenderness at CS from 4/5 to 3+/5, dec spasm at CS from 4/5 to 3+/5. Manual msl strength at CS 3/5 on 0-5 scale. Inc Endurance from poor+ to fair-, Balance static/dynamic: Sit: F+/F+, Std: F+/F+. Pt has min difficulty to get up from low height chair. Pt c/o mod pain during bed mobility & transfers. Pt is still unable to sleep on stomach for > 20-25 min, has difficulty sleeping on back for >15-20 min, sit for >15-20 min & stand for >10-12 min, reach for object from floor due to pain. C/o mod pain during dressing and grooming requiring mod A to complete, Pt is able to look up, down & around with min pain. Pt is still unable to reach overhead and behind back and has hard time putting his clothes on without assistance and extra time to complete. Pt has been given strategies to use to reduce headaches, pt continues to have headaches rating 6-7/10 on 0/10 scale. Pt is alert, oriented, coop x3 and well motivated.</p> <p>Continue OT 2-3/wk-4wks.</p>					
19. SIGNATURE (or name of professional, including prof. Designation) 		20. DATE 11/5/10		21. <input checked="" type="checkbox"/> CONTINUE SERVICES OR <input type="checkbox"/> DC SERVICES	
22. FUNCTIONAL LEVEL (at end of billing period - Relate your documentation to functional outcome and list problems still					
23. SERVICE DATES FROM THROUGH					

DEPARTMENT OF HEALTH AND HUMAN RESOURCES HEALTH CARE FINANCING ADMINISTRATION			FORM APPROVED OMB NO. 0938-0227	
PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION (COMPLETE FOR INITIAL CLAIMS ONLY)				
1 PATIENT'S LAST NAME		FIRST NAME	M.I.	2 PROVIDER NO.
4 PROVIDER NAME NEW ERA PT SERVICES		5 MEDICAL RECORD NO (Optional)		6 ONSET DATE 3/27/2011
7 SOC DATE 4/14/2011		10 TREATMENT DIAGNOSIS NECK PAIN. RADIATING LOW BACK PAIN.		11 VISITS FROM SOC.
8 TYPE <input checked="" type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> RT <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW		9 PRIMARY DIAGNOSIS (Pertinent Medical D.X.) CERVICAL WIPLASH. LOW BACK PAIN. concussion		
12. PLAN OF TREATMENT FUNCTIONAL GOALS GOALS (Short Term) 1) Decrease pain in low back and neck up to 4/10 2) Increase muscle strength by 1/2 grade in neck and low back 3) Decrease tenderness up to 2/5 at low back on 0-5 scale. 4) Independent in HEP OUTCOME (Long Term). 1) Decrease pain in low back and neck up to 2/10 2) Increase muscle strength by 1 grade in neck and low back 3) Decrease tenderness up to 1/5 on 0-5 scale 4) Able to do ADL and IADL in WFL			PLAN 1. MHP/EMS TO CERVICAL/LUMBAR X 20 MINUTES 2. STM/MFR to CERVICAL/LUMBAR X 16 MINUTES 3. US LOW CERVICAL/LUMBAR X 8 MINUTES X 0.8-1.2 W/CM2 4. Ther exc for strengthening x 15-45 min 5. THERAPEUTIC ACTIVITIES X 15 MINUTES 6. HEP	
13. SIGNATURE (professional establishing POC including prof. designation)  DR. H-14-11			14. FREQ/DURATION (e.g., 3/1WK, x 4 Wks.) 2-3 x week for 4 weeks	
15. PHYSICIAN'S SIGNATURE  MD 5/2/11			17 CERTIFICATION 4/7/2011 TO 5/6/2011 18 ON FILE (Print /type physician's name) Dr. Hoban	
20. INITIAL ASSESSMENT (History, medical complications, level of function at start of care. Reason for referral) 42 year old male came to clinic complaining about neck, shoulders and low back pain, which started after a car accident on 3/27/2010. Pt is evaluated as per doctor's order today. Pain in neck is 8/10, dull aching and radiating to both shoulders, with tingling in LT UE. Pain in low back is 8/10, dull aching to sharp radiating to Lt hip and thigh.. Trigger point is absent. Tenderness is 3+/5 on 0-5 scale at L1-5, 3/5 on both upper trapezius. C4-7. ROM in neck is severely limited for SF, rotation, extension, flexion due to pain. ROM in LB is severely limited for flexion, moderately limited for, extension, rotation and for SF. MMT in neck is 3+/5 and 3-/5 for LB. Balance is good in static sitting and standing; F+/G in dynamic sitting and standing.. Gait: slow with stiff back, unequal step length and absent heel to toe pattern.. Pt has moderate difficulty in reaching overhead, going up/down stairs, lifting, carrying, pulling/pushing. Pt is unable to sit > 20-25 minutes, stand > 10 minutes and walk > 10 minutes. Pt has radiating neck and low back pain, has fair rehab potential and needs skill PT treatment.			19 PRIOR HOSPITALIZATION FROM TO <input type="checkbox"/> N/A	
21. FUNCTIONAL LEVEL (End of billing period) PROGRESS REPORT <input type="checkbox"/> CONTINUE SERVICES OR <input type="checkbox"/> DC SERVICES				
22. SERVICE DATES FROM THROUGH				

DEPARTMENT OF HEALTH AND HUMAN RESOURCES HEALTH CARE FINANCING ADMINISTRATION		Location <input checked="" type="checkbox"/> Clinic <input type="checkbox"/> Patient's home		OMB NO. 09
UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION (Complete for interim to Discharge Claims. Photocopy of HCFA-700 or 701 is required)				
1. PATIENT'S LAST NAME		2. PROVIDER NO.		3. HICN
4. PROVIDER NAME NEW ERA PT SERVICES		5. MEDICAL RECORD NO. (Optional)		6. ONSET DATE 3/27/2011
8. TYPE: <input checked="" type="checkbox"/> P T <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> R T <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW		9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.) LOW BACK PAIN		7. SOC DATE 4/14/2011
		10. TREATMENT DIAGNOSIS LOW BACK PAIN		11. VISITS FROM SOC
		12. FREQ/DURATION (e.g., 3 wk x 4 wk) 2-3 WK X 4WKS		
13. CURRENT PLAN UPDATE, FUNCTIONAL GOALS (Specify changes to goals & plan of care)			PLAN	
GOALS (Short Term) 1) Decrease pain in low back and neck up to 4/10 2) Increase muscle strength by 1/2 grade in neck and low back 3) Decrease tenderness up to 2/5 at low back on 0-5 scale. 4) Independent in HEP OUTCOME (Long Term) GOALS met not met 1) Decrease pain in low back and neck up to 2/10 2) Increase muscle strength by 1 grade in neck and low back 3) Decrease tenderness up to 1/5 on 0-5 scale 4) Able to do ADL and IADL in WFL			1 MHP/EMS TO LUMBAR X 20 MINUTES 2 STM/MFR to LUMBAR X 16 MINUTES 3. US LOW LUMBAR X 8 MINUTES X 0.8-1.2 W/CM2 4. Ther exc for strengthening x 15-45 min 5 THERAPEUTIC ACTIVITIES X 15 MINUTES HEP	
14. I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES.			14. RECERTIFICATION	
15. PHYSICIAN'S SIGNATURE			5/3/2011 to 6/2/2011	
16. DATE			17. ON FILE (Print/type physician's name) Dr. Hoban	
18. REASON (S) FOR CONTINUING TREATMENT THIS BILLING PERIOD (Clarify goals and necessity for continued skilled care)				
Pt is re-evaluated today as per doctor's order. Pain in low back is 8/10, dull aching to sharp radiating to Lt hip and thigh.. Trigger point is absent. Tenderness is 3+/5 on 0-5 scale at L1-5. ROM in LB is severely limited for flexion, moderately limited for, extension, rotation and for SF. MMT is 3-/5 for LB. Balance is good in static sitting and standing; F+/G in dynamic sitting and standing.. Gait: slow with stiff back, unequal step length and absent heel to toe pattern.. Pt has moderate difficulty in reaching overhead, going up/down stairs, lifting, carrying, pulling/pushing ># 3 pound weight. Pt is unable to sit > 40 minutes, stand > 7-8 minutes and walk > 5-10 minutes. Pt has low back pain, has good rehab potential and needs skill PT treatment				
19. SIGNATURE (or name of professional, including prof. Designation)		20. DATE		21.
		5/3/2011		<input checked="" type="checkbox"/> CONTINUE SERVICES OR <input type="checkbox"/> DC SERVICES
22. FUNCTIONAL LEVEL (at end of billing period - Relate your documentation to functional outcome and list problems still)				
23. SERVICE DATES				
FROM THROUGH				

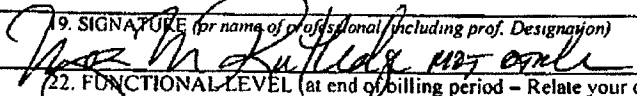
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
HEALTH CARE FINANCING ADMINISTRATORLocation ☒ Clinic ☐ P's homeFORM APPROVAL
OMB NO. 0938-01**UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION**

(Complete for interim to Discharge Claims. Photocopy of HCFA-700 or 701 is required)

1. PATIENT'S LAST NAME		FIRST NAME		M.I.		2. PROVIDER NO.	3. HICN
4. PROVIDER NAME NEW ERA PT SERVICES		5. MEDICAL RECORD NO. (Optional)		6. ONSET DATE 03/27/2011		7. SOC DATE 04/14/2011	
8. TYPE <input type="checkbox"/> P T <input checked="" type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> R T <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW		9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.) WHIPLASH, CERVICAL STRAIN, CONCUSSION		10. TREATMENT DIAGNOSIS Neck Pain, Upper/Mid Back Pain, Shoulder Pain, Headache, Inc. Tend and Stiffness, Decline in functional ability		11. VISITS FROM SOC.	
		12. FREQ/DURATION (e.g. 3 wk. x 4 wk) 2-3 WK X 4WKS					
13. CURRENT PLAN UPDATE. FUNCTIONAL GOALS (Specify changes to goals & plan of care)				PLAN			
GOALS (Short Term) 1. Increase UE strength to 3+/5 2. Increase Endurance to Fair 3. Increase coordination to Fair 4. Instruct on HEP & energy conservation techniques 5. Establish home exercise program 6. Increase IADL's to independent 7. Decrease pain to 3-4/10 OUTCOME (Long Term) 1. Increase UE strength to WFL 2. Increase Endurance to Fair+ 3. Increase coordination to Good 4. Decrease pain to 0-2/10				1. Thx aarom /arom/pre /stretching/strengthening at CS/Bil Shoulders 2. Instruct & educate HEP. 3. Therapeutic US to CS/trapezius 3.3MHz W.5W/cm2 @20% puls min. 4. MHP with IFC to CS/Bil Shoulders 5. Manual Therapy to CS/Bil Shoulders 6. IADL retraining 7. Therapeutic/Functional Activity to improve functional ROM & coordination 8. Energy Conservation training			
I HAVE REVIEWED THIS PLAN OF TREATMENT AND CERTIFY A CONTINUING NEED FOR SERVICES. <input type="checkbox"/> N/A <input type="checkbox"/> DC 15. PHYSICIAN'S SIGNATURE 				14. RECERTIFICATION 05/17/2011 THROUGH 06/16/2011 <input type="checkbox"/>			
16. DATE 6/9/11				17. ON FILE (Print /type physician's name) DR SEAN HOBAN			

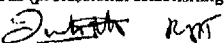
18. REASON (S) FOR CONTINUING TREATMENT THIS BILLING PERIOD (Clarify goals and necessity for continued skilled care)

Pt received 12 OT tx sessions for this billing period. Pt functional status is as follows: Patient is currently experiencing cervical pain which he rates as a 5/10 intensity, tenderness at 3/5 on 5/5 scale, decreased UE strength (R:3+/5), IFC with MHP to CS/TS, STM with MFR to CS/TS, jt mobs with grade 1 & 2 to CS/TS, US to CS/trapezius msl groups 3.3 mhz w/cm2. Cervical/Thoracic stretches and AROM, Bilateral shoulder wheel 10x 1 reps each, AROM exercises 10 x 1 reps each (all planes), PRE's with yellow theraband bilateral shoulder/elbow flexion/extension, presses, rows. Instruct/educate with ADL/IADL compensatory and energy conservation technique. Core strengthening exercises 10x 1 rep each. He requires assistance with ADL's at times (mod I/SBA) secondary to increased pain and stiffness. He has difficulty with tasks which require overhead reaching/lifting, and he is experiencing some decreased endurance (endurance: Fair+). Patient also reports numbness and tingling at times down R UE, which is having a negative effect on his GMC/FMC during daily tasks. Patient continues to benefit from OT to improve UE strength, ROM, endurance, coordination, ADL/IADL ability, safety awareness and to decrease pain. Patient displays motivation to improve his current level of function to previous status. Pt is alert, oriented, coop x3, and well-motivated. Continue OT 2-3/wk -4 wks.

19. SIGNATURE (for name of professional, including prof. Designation) 	20. DATE 5/17/2011	21. <input checked="" type="checkbox"/> CONTINUE SERVICES OR <input type="checkbox"/> DC SERVICES
22. FUNCTIONAL LEVEL (at end of billing period - Relate your documentation to functional outcome and list problems still)		

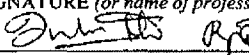
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
HEALTH CARE FINANCING ADMINISTRATIONFORM APPROVED
OMB NO. 0938-0227

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION (COMPLETE FOR INITIAL CLAIMS ONLY)

1. PATIENT'S LAST NAME		FIRST NAME		M.I.	2. PROVIDER NO.	3. HICN
4. PROVIDER NAME POINTE PHYSICAL THERAPY		5. MEDICAL RECORD NO. (Optional)		6. ONSET DATE 01.06.2010	7. SOC DATE 01.21.2010	
8. TYPE: <input checked="" type="checkbox"/> P T <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> R T <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW		9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.) THORASIC/LS STRAIN		10. TREATMENT DIAGNOSIS THORASIC/LS STRAIN		11. VISITS FROM SOC.
12. PLAN OF TREATMENT FUNCTIONAL GOALS GOALS (Short Term IN 2 WEEKS IN 4 WEEKS) 1.DEC PAIN @CS &LS TO 5/10 ON 0/10 SCALE 2.TENDERNESS @LOWER BACK TO 3/5 ON 0/5 SCALE 3.INC ROM OF CS &LS TO 5-10 DEG IN ALL PLANES 4.INITIAE HEP OUTCOME (Long Term IN 4 WEEKS) 1.DEC PAIN @CS &LS TO 0-1/10 ON 0/10 SCALE 2.DEC TENDERNESS @LOWER BACK TO 0-1/5 ON 0/5 SCALE 3. INC ROM OF CS &LS WFL 4.INC MUSCLE POWER OF CA LS AND BOTH UE AND LE 5. INC FUNCTIONAL MOBILITY IN ADL PAIN FREE				PLAN 1.FC WITH MHP TO CS AND LOWER BACK X 15 MTS 2.THX US INCLUDES 3.3 MHZ@1.4W/CM2 X 8 MT TO LOWER BACK 3.THX EXCS INCLUDES AROM,PROM PRE AND STRETCHING EXCS TO THE CS ,LS AND ALSO TO BOTH UE AND LE X 15-30 MTS 4.MFR TO NECK AND LS X 10 MTS 5.INSTRUCT AND EDUCATE HEP		
13. SIGNATURE (professional establishing POC including prof. designation) 				14. FREQ/DURATION (e.g., 3/Wk. x 4 Wk.) 2-3/WK X 4 WK		
I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE <input type="checkbox"/> N/A				17. CERTIFICATION FROM 1.20.2010 THROUGH 02.19.2010 <input type="checkbox"/> N/A		
15. PHYSICIAN'S SIGNATURE				18. ON FILE (Print /type physician's name) GUNABALAN		
20. INITIAL ASSESSMENT (History, medical complications, level of function at start of care. Reason for referral)				19. PRIOR HOSPITALIZATION FROM TO <input type="checkbox"/> N/A		

a 22 yr old male patient came to the clinic with diagnosis of cervical and lumbar strain .the patient reported that the pain has started after he met with an accident on 01.06.2010..pt c/o severe pain and stiffness in the neck and back and radiating to both le causing difficulty in fn mobility and adl ptof:pt was independent in adl and fn mobility before this episode.social history: patient finished the high school .past medical history : n/a :functional status : pain level at cs & ls is about 8-9 /10 on 0/10 scale.the tenderness is about 4/5 On 0/5 scale @cs aand ls.spasm is about 3-4/5 on 0-5 scale.arom at cs is 0-10,ext 0-10,lat flx 0-10 ,rot 0-15.arom @ls flex 0-5,ext 0-5side flex 0-8,rot 0- 5. manual muscle power is about 3-/5 on 0-5 scale.spasm is about 4/5 on 0-5 scale.endurance is poor + .balance static/dynamic :sit f/f-std .patient walks with an antalgic gait for 5-10 mts.pt has mod difficulty with going up and down ,getting from a chair ,going in and out of car aalso mod difficulty with bed mobility,grooming ,dressing and over the head activities.pt cannot reach to floor to pick up an object due to pain.pt cannot lie on stomach /back for 10 -15 mts and mod diff with sitting and standing for 10-15 mts.patient has difficulty with looking up and down ,reaching behind back special tests: positive compression and quadrant test also positive slr test precautions : pt is advised to not to lift heavy wts,repeated forward bending and sudden twisting and turning.pt is alert and oriented and has a good rehab potential.

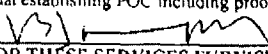
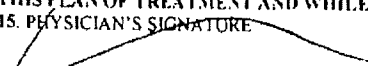
22 b127918

DEPARTMENT OF HEALTH AND HUMAN RESOURCES HEALTH CARE FINANCING ADMINISTRATION		Location <input checked="" type="checkbox"/> Clinic <input type="checkbox"/> Patient's home		FORM APPROVE OMB NO. 0938-027	
UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION (Complete for interim to Discharge Claims. Photocopy of HCFA-700 or 701 is required)					
1. PATIENT'S LAST NAME		FIRST NAME		2. PROVIDER NO.	
4. PROVIDER NAME POINT PHYSICAL THERAPY		5. MEDICAL RECORD NO. (Optional)		6. ONSET DATE 01.06.2010	
8. TYPE: <input checked="" type="checkbox"/> P T <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> R T <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW		9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.) THORASIC/LS STRAIN		10. TREATMENT DIAGNOSIS THORASIC/LS STRAIN	
		12. FREQ/DURATION (e.g., 3 wk .x 4 wk) 2-3 WK X 4WKS		11. VISITS FROM SOC.	
13. CURRENT PLAN UPDATE, FUNCTIONAL GOALS (Specify changes to goals & plan of care)			PLAN		
GOALS OUTCOME (Long Term) Goals <input type="checkbox"/> met <input checked="" type="checkbox"/> not met 1. DEC PAIN @CS & LS TO 0-1/10 ON 0/10 SCALE 2. DEC TENDERNESS @LOWER BACK TO 0-1/5 ON 0/5 SCALE 3. INC ROM OF CS & LS WFL 4. INC MUSCLE POWER OF LS AND BOTH UE AND LE 5. INC FUNCTIONAL MOBILITY IN ADL PAIN FREE			IFC WITH MHP TO LOWER BACK X 15 MTS 2. THX US INCLUDES 1 MHZ@1.3W/CM2 X 8 MT TO LOWER BACK 3. THX EXCS INCLUDES AROM, PROM PRE AND STRETCHING EXCS TO THE LS AND ALSO TO LE X 1 MTS 4. MFR TO LS X 10 MTS 5. INSTRUCT AND EDUCATE HEP		
I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. <input type="checkbox"/> N/A <input type="checkbox"/> DC 15. PHYSICIAN'S SIGNATURE			14. RECERTIFICATION FROM 03.23.2010 THROUGH 4.22.2010 N/A <input type="checkbox"/>		
16. DATE			17. ON FILE (Print /type physician's name) Dr GUNABALAN		
18. REASON (S) FOR CONTINUING TREATMENT THIS BILLING PERIOD (Clarify goals and necessity for continued skilled care) Patient received 11 PT tx sessions during the last billing period. Pt has progressed with each treatment sessions since SOC and HIS treatment goals. Pt's functional status is as follows.: patient demon strated decpain level at ls is about 7-8 /10 on 0/10 scale. the tenderness is about 3+/5 On 0/5 scale @ ls. spasm is about 3-4/5 on 0-5 scale. arom at lower back is restricted due to pain . manual muscle power is about 3/5 on 0-5 scale. endurance is fair- . balance static/dynamic :sit good /fstd good .pt has mod difficulty with going up and down ,getting from a chair ,going in and out of car aalso mod/min difficulty with bed mobility. pt has max difficulty to reach to floor to pick up an object due to pain. pt cannot lie on stomach / for >30 mts and mod diff with sitting and standing for > 10-15 mts.. pt is alert and oriented and is well motivated. continue pt 2-3/wk-4wks.					
19. SIGNATURE (or name of professional, including prof. Designation)		20. DATE		21.	
				<input checked="" type="checkbox"/> CONTINUE SERVICES OR <input type="checkbox"/> DC SERVICES	
22. FUNCTIONAL LEVEL (at end of billing period - Relate your documentation to functional outcome and list problems still					
				23. SERVICE DATES FROM THROUGH	

22K 360118

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
HEALTH CARE FINANCING ADMINISTRATIONFORM APPROVED
OMB NO. 0938-0227

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION (COMPLETE FOR INITIAL CLAIMS ONLY)

1. PATIENT'S LAST NAME		FIRST NAME		M.I.	2. PROVIDER NO	3. HICN
4. PROVIDER NAME NEW ERA		5. MEDICAL RECORD NO. (Optional)		6. ONSET DATE 6/18/09		7. SOC DATE 7/09/09
8. TYPE: <input checked="" type="checkbox"/> P T <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> R T <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW		9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.) Lumbar strain		10. TREATMENT DIAGNOSIS LS pain, inc stiffness, dec functional mobility		11. VISITS FROM SOC.
12. PLAN OF TREATMENT FUNCTIONAL GOALS GOALS (Short Term) 1. Dec pain at LS to 5/10 at 0-10 scale in 2 wks. 2. Dec tend at LS to 2/5 at 0-5 scale in 2 wks. 3. Inc AROM at LS by 10deg in all planes. 4. Inc mmstr at LS to 1/2 grade. 5. Establish HEP. OUTCOME (Long Term) 1. Dec pain at LS 0-1/10 on 0-10 scale in 4-6wks 2. Dec tend at LS 0-1/5 on 0-5 scale in 4-6wks. 3. Inc AROM at LS to WFL. 4. Inc mmstr at LS to WFL. 5. Inc functional mobility in ADL's to pain free.				PLAN 1. Tx aarom/arom/pre/stretching at LS 2. Instruct & educate in HEP. 3. U.S to 1MHz 1.3w/cm2 at LS 4. MHP with IFC to LS 5. Manual therapy to LS		
13. SIGNATURE (professional establishing POC including proof designation) 				14. FREQ/DURATION (e.g., 3/Wk x 4 Wk.) 2-3/wk x 4/WK		
15. I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE <input type="checkbox"/> N/A 15. PHYSICIAN'S SIGNATURE  16. DATE 9/1/09				17. CERTIFICATION FROM 7/09/09 THROUGH 8/08/09 <input type="checkbox"/> N/A 18. ON FILE (Print type physician's name) Dr. Ruden		
20. INITIAL ASSESSMENT (History, medical complications, level of function at Start of care. Reason for referral)				19. PRIOR HOSPITALIZATION FROM TO <input type="checkbox"/> N/A		

This 30 yr old male came to the clinic with the primary diagnoses of lumbar strain. Pt states that he was driving when was hit by a car that crossed the stop sign: the accident was on 5/18/09 and the patient stated he started having pain at his lower back since then aggravating one month later. At present pt c/o severe pain & stiffness at LS causing him difficulties in functional mobilities. Pt informs that pain occasionally radiates to B LE. **PAST MEDICAL HISTORY:** N/S. Medication: Vicodin, SOMA, Motrin. **SOCIAL HISTORY:** Pt lives alone in a house. **PLOF:** Pt states he was independent in ADL's prior to the accident. **FUNCTIONAL STATUS:** Pain level at LS is 7/10 on 0-10 scale. Tenderness at L2- LS 3+/5 on 0-5 scale. spasm at LS 3+/5 on 0-5 scale. AROM at LS flex 0-10 deg, side flex 0-5 deg, ext 0-5 deg, rot 0 deg. Manual msl strength at LS 3-/5 on 0-5 scale. Endurance for sitting poor, standing and dynamic activities poor. Balance for dynamic activities fair. Pt has max difficulty to go up & down stairs. Pt needs mod A to get up from low height chair. Pt has mod difficulty using bathtub. Pt c/o max pain during bed mobility & transfers. Pt is unable to sleep on stomach < 5-10 minutes. sleep on back for > 5-10 min, sit for > 15-20 min & stand for > 5 min, reach for object from floor due to pain. C/o pain during dressing and grooming. Pt's co-ordination is good. Sensation normal. **SPECIAL TESTS:** SLR -ve. **PRECAUTIONS:** patient is advised not to bend, avoid lifting heavy weight and avoid twisting and turning. He is also instructed to maintain proper posture. Pt is alert and oriented and has good rehab potential.

21. FUNCTIONAL LEVEL (End of billing period) PROGRESS REPORT ☐ CONTINUE SERVICES OR ☐ DC SERVICES22. SERVICE DATES
FROM THROUGH

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
HEALTH CARE FINANCING ADMINISTRATIONLocation ☒ Clinic ☐ Patient's homeFORM APPROVAL
OMB NO. 0938-01**UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION**

(Complete for interim to Discharge Claims. Photocopy of HCFA-700 or 701 is required)

1. PATIENT'S LAST NAME		FIRST NAME		M.I.	2. PROVIDER NO.	3. HICN
4. PROVIDER NAME New Era		5. MEDICAL RECORD NO. (Optional)		6. ONSET DATE 6/18/09	7. SOC DATE 7/09/09	
8. TYPE: <input checked="" type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> RT <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW		9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.) Lumbar strain		10. TREATMENT DIAGNOSIS LS pain, inc stiffness, dec functional mobility		11. VISITS FROM SOC.
12. FREQ/DURATION (e.g. 3 wk x 4 wk) 2-3 WK X 4WKS						
13. CURRENT PLAN UPDATE. FUNCTIONAL GOALS (Specify changes to goals & plan of care)				PLAN		
GOALS (Short Term) 1. Dec pain at LS to 5/10 at 0-10 scale in 2 wks. 2. Dec tend at LS to 2/5 at 0-5 scale in 2 wks. 3. Inc AROM at LS by 10deg in all planes. 4. Inc mmstr at LS to 1/2 grade. 5. Establish HEP. OUTCOME (Long Term) 1. Dec pain at LS 0-1/10 on 0-10 scale in 4-6wks 2. Dec tend at LS 0-1/5 on 0-5 scale in 4-6wks. 3. Inc AROM at LS to WFL. 4. Inc mmstr at LS to WFL. 5. Inc functional mobility in ADL's to pain free. GOALS <input type="checkbox"/> met <input type="checkbox"/> not met				1. Tx aarom/arom/pre/stretching at LS 2. Instruct & educate in HEP. 3. U.S to 1MHz 1.3w/cm2 at LS 4. MHP with IFC to LS 5. Manual therapy to LS		
I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. <input type="checkbox"/> N/A <input type="checkbox"/> DC 15. PHYSICIAN SIGNATURE				14. RECERTIFICATION <input type="checkbox"/> N/A 8/09/09 THROUGH 9/08/09 17. ON FILE (Print/type physician's name) Dr. Ruden		
18. REASON(S) FOR CONTINUING TREATMENT THIS BILLING PERIOD (Clarify goals and necessity for continued skilled care) Pt received 10 TX sessions this billing period. Pt has shown progress with each session towards set goals. Functional status of patient is as follows: pain level at LS dec from 7 to 7-6+/10 on 0-10 scale. Tenderness at L2-L5 dec from 3+ to 3/5 on 0-5 scale, spasm at LS is 3+/5 on 0-5 scale. AROM at LS flex inc from 10 to 0-15 deg, side flex 0-5 deg, ext 0-5 deg, rot 0-5 deg. Manual msl strength at LS is 3-/5 on 0-5 scale. Endurance for sitting and standing and dynamic activities improved from poor to poor+. Balance for dynamic activities is fair. Pt still has mod difficulty to go up & down stairs. Pt still needs mod A to stand from low height chair. Pt still has mod-min difficulty using bathtub. Pt still c/o mod pain during bed mobility & transfers. Pt is still unable to sleep on stomach < 5-10 minutes, sleep on back for > 5-10 min, sit for > 15-20 min & stand for > 5 min, reach for object from floor due to pain. Pt still c/o pain during dressing and grooming. Pt's co-ordination is good. Pt demo HEP with min difficulty. Pt has good rehab potential and would benefit from continued therapy 2 to 3 times a week for 4 weeks to achieve set goals.						
19. SIGNATURE (or name of professional, including prof. Designation)				20. DATE		21. <input checked="" type="checkbox"/> CONTINUE SERVICES OR <input type="checkbox"/> DC SERVICES
22. FUNCTIONAL LEVEL (at end of billing period - Relate your documentation to functional outcome and list problems still						